

May 6, 2003

Re: MDR #: M2-03-0810-01-SS
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ____ for an independent review. ____ has performed an independent review of the medical records to determine medical necessity. In performing this review, ____ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Orthopedic Surgery/Spine.

Clinical History:

This female claimant was injured on her job on ____, with complaints of persistent posterior neck pain and bilateral shoulder pains to her hands, left greater than right.

Reports of an MRI dated 07/31/01, reveal multi-level degenerative spondylosis of the cervical spine at C3-4, C4-5, C5-6 and C6-7, and foraminal stenosis on the left at C2-3, on the left at C3-4, on the right at C4-5, bilaterally at C5-6, and bilaterally at C6-7. There is also notation of mild central spinal canal stenosis at C5-6 and C6-7.

CT myelogram dated 05/30/02, reveals foraminal stenosis on the left at C3-4, on the right at C4-5, decreased disc height at C5-6, and bilateral foraminal stenosis at C6-7.

Disputed Services:

Anterior cervical discectomy and fusion at C3-4 and C5-6.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the procedure named above is not medically necessary in this case.

Rationale for Decision:

Based on the reports of abnormalities at C2-3, C3-4, C4-5, C5-6 and C6-7, the requested procedure would not significantly benefit this patient.

I am the Secretary and General Counsel of ____ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ____ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on May 6, 2003.

Sincerely,